

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04526

4555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) James		First James	Middle Henry
4. DATE OF DEATH April 1 1958		Month April	Day 1
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			8. DATE OF BIRTH November 29, 1905
			9. AGE (In years lost birthday) 52 yrs.
			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Lake Aaron	
14. MOTHER'S MAIDEN NAME Clara Estelle Fitzhugh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown	
16. SOCIAL SECURITY NO. 217-0-8368		17. INFORMANT RECORDS: Eastern Shore State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus		INTERVAL BETWEEN ONSET AND DEATH -	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 465X			
(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operated on for double hydrocele - March 14, 1958		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 1958 , to April 1, 1958 , that I last saw the deceased alive on April 1, 1958 , and that death occurred at 8:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eastern Shore State Hospital		DATE SIGNED 4-2-58	
ACTUAL SIGNATURE Ettore DeFilippis		PHYSICIAN'S NAME (Type) Ettore DeFilippis	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/58	
22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem Park		22d. LOCATION (City, town, or county) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.	
24a. REG'D. BY REGISTRAR Altrouch		24b. REGISTRAR'S SIGNATURE Altrouch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4536

CERTIFICATE OF DEATH

04527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 243 Goldsborough Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mollie		First E.	Middle Abbott	Last Abbott	4. DATE OF DEATH April	Month 5.	Day 19	Year 58	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/ 1876	9. AGE (In years lost birthday) 81	IF UNDER 1 YEAR Months 81	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Golden Hill Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Wilson				14. MOTHER'S MAIDEN NAME Eliza Phillips					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James L. Abbott		Address Taylors Is. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 6 days			
		arteriosclerosis				under			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/21 , 1958, to 4/5 , 1958, that I last saw the deceased alive on 4/5 , 1958, and that death occurred at 8 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Alfred R. Maryanov M.D.				ADDRESS (Street, city or town, state) 136 RACE ST.		DATE SIGNED 4/7/58			
PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV		CAMBRIDGE, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58		22c. NAME OF CEMETERY OR CREMATORIAL Brick Church Taylors Is.		22d. LOCATION (City, town, or county) Taylors Is. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE Alfred R. Maryanov			

MICHIGAN STATE DEPARTMENT OF HEALTH - BATTINGSBURG 18

CERTIFICATE OF DEATH

BUREAU N.Y.

APR 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04528

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 10 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bay Hights Cambridge Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert	First King	Middle Baldwin	4. DATE OF DEATH Month April Day 4 , Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Driller		10b. KIND OF BUSINESS OR INDUSTRY Well Drilling	
11. BIRTHPLACE (State or foreign country) Mt. Clements Mich.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur W. Baldwin		14. MOTHER'S MAIDEN NAME Edna C. King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 300-09-5654	
17. INFORMANT Mrs. Robert K. Baldwin		Address Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO LOBAR PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH UNDET.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ALCOHOLISM DUE TO UNDET.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) UNDET.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 15st.
20f. (City or town) Cambridge (County) Md. (State) MD		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Alfred R. Morgan	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/5/58
EXAMINER'S NAME (Type) LeCompte Funeral Service	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/7/58 22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park 22d. LOCATION (City, town, or county) (State) Cambridge Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	24a. REC'D BY REGISTRAR APR 9 '58 24b. REGISTRAR'S SIGNATURE Alfred R. Morgan		

EXAMINER'S CERTIFICATE OF DEATH
MEDICAL EXAMINER'S OFFICE - SALINAS, CALIFORNIA

BUREAU X. A.

APR 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04529

4537 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorch.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge		d. STREET ADDRESS 202 Franklin St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas Milbourne	Middle Bramble, Jr.	Lost	4. DATE OF DEATH April 19, 1958	Month April	Day 19	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 5	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk & Deliveryman		10b. KIND OF BUSINESS OR INDUSTRY Feed & Seed Store		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME T. Milbourne Bramble, Sr.		14. MOTHER'S MAIDEN NAME Sallie L. Mills					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-9676		17. INFORMANT Mrs. Elizabeth C. Bramble, 202 Franklin St., Camb. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X		RUPTURED ANEURISM ABDOMINAL AORTA					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Hypertension (Cardio Vascular Disease)					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-27-58 , 19, to 4-19-58 , 19, that I last saw the deceased alive on 4-19-58 , 19, and that death occurred at 8:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Albert E. Bunker</i> M.D. 200 Maryland Avenue DATE SIGNED 4-21-58							
PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D.		Cambridge, Maryland					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 22, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Howard</i>		ADDRESS Cambridge, Md.		24e. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE <i>Albert E. Bunker</i>	

THE STATE OF NEW YORK - SALVATION ARMY

CERTIFICATE OF DEATH

BUREAU L.

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04530

4538 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md. 13		d. STREET ADDRESS 12 Church St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lula		First Stapleforte	Middle Brooks	4. DATE OF DEATH April	Month 5	Day 19	Year 58
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/21/1984	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Lakesville Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Stapleforte		14. MOTHER'S MAIDEN NAME Laura Jones					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Donald Brooks		Address Huntington N. Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Infarction INTERVAL BETWEEN ONSET AND DEATH 1 wh							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO Arteriosclerotic Cardiovascular Disease 3 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 24, 1954</u> , to <u>April 4, 1958</u> , that I last saw the deceased alive on <u>April 4, 1958</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge Md. DATE SIGNED 4-5-58							
ACTUAL SIGNATURE <u>Dr. Bannerman</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/58		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR APR 9 '58	
						24b. REGISTRAR'S SIGNATURE D. L. S.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04531

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4539

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hurlock - Rural				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital				d. STREET ADDRESS Near Williamsburg		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Bertha		First	Middle M.	Last Cannon	4. DATE OF DEATH April 8	Month Day Year 1958		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 17, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Sussex County, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Rogers		14. MOTHER'S MAIDEN NAME Alvertia Towers						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Enos C. Cannon, Hurlock, Maryland, R.F.D.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c)		Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/10/58		
EXAMINER'S NAME (Type) Dr. John Mace Jr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 12, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS		24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>		
VS. A15ME SM 2/57								

APR 14 1969

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4557

CERTIFICATE OF DEATH

04532

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS 113 N. Harrison St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fischer's Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANNIE		First	Middle	Lost	4. DATE OF DEATH April 9, 1958	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1864		9. AGE (In years lost birthday) 93 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Purnell Fleetwood		14. MOTHER'S MAIDEN NAME Jane Harris							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure DUE TO 420.1 INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Coronary Arteriosclerosis ONSET AND DEATH DUE TO (c) Generalized Arteriosclerosis 20 yrs. 25 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 812	(County) 1958	(State) 419
21. I certify that I attended the deceased from 812 , 1958, to 419 , 1958, that I last saw the deceased alive on 417 , 1958, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Preston, Maryland DATE SIGNED Harold B. Plummer									
ACTUAL SIGNATURE Harold B. Plummer M.D.									
PHYSICIAN'S NAME (Type) Dr. Harold B. Plummer PRESTON, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 12, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery		22d. LOCATION (City, town, or county) Easton, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE Apr 14 '58		24b. REGISTRAR'S SIGNATURE Alvin			

CERTIFICATE OF DEATH

BUREAU OF INVESTIGATION

APR 14 1953

RECEIVED

BUREAU L

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04533

4540 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 108 Academy Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First William	Middle Harvey	Last Cheezum	4. DATE OF DEATH April 4, 1958	Month Month	Day Day	Year Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1900 2/18/188	9. AGE (In years (last birthday) yrs. 70	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber self employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Preston, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John F. Cheezum		14. MOTHER'S MAIDEN NAME Mary Ross						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-0944		17. INFORMANT Beatrice C. Cheezum, 108 Academy St., Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Arterio sclerotic nephritis				INTERVAL BETWEEN ONSET AND DEATH 14		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) } DUE TO } (c)		Coronary occlusion				6 months		
Coronary Heart Disease						2 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____ 3/20, 1958 to _____ 4/4, 1958 that I last saw the deceased alive on _____ 4/4, 1958, and that death occurred at 5:00 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Lawrence Maryanov</i>		ADDRESS (Street, city or town, state) 136 Race St						
PHYSICIAN'S NAME (Type) Lawrence Maryanov		DATE SIGNED 4/4/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Apr. 6, 1958		22b. DATE THEREOF Apr. 6, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Methodist Church Cemetery		22d. LOCATION (City, town, or county) Mardella, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Thomas</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE <i>John R. Thomas</i>		

CERTIFICATE OF DEATH

RECEIVED
APR 7 1958
BUREAU X

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04536

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for other files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		4541		00	
1. PLACE OF DEATH a. COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XXXXXX		d. STREET ADDRESS 1602 High St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julia Stewart Edwards		First	Middle	4. DATE OF DEATH April	Month Day Year 26 19 58
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/98	9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry J. Stewart		14. MOTHER'S MAIDEN NAME Catherine Elliott		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 213 16 7419		17. INFORMANT Melvin Fountaine Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Instant	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 260 X Diabetes mellitus.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/27/58	
EXAMINER'S NAME (Type) John Mace Jr.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/58		22d. LOCATION (City, town, or county) Cambridge (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Clark Jr.		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bethel Cemetery Cambridge, Md.		24a. REC'D BY REGISTRAR DATE APR 30 '58	
				24b. REGISTRAR'S SIGNATURE Albert E. Smith	

RECEIVED

APR 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04537

4542

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				d. STREET ADDRESS Near Rhodesdale			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Treacy	Middle Cole	Last Elbert	4. DATE OF DEATH April	Month April	Day 10	Year 19 58
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1904	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nathan Jackson				14. MOTHER'S MAIDEN NAME Estella Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-1528	17. INFORMANT Robert Neal, Hurlock, Maryland	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Deebeter Comus Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Deebete, Mellata (c)				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 7</u> , 1958, to <u>Apr 10</u> , 1958, that I last saw the deceased alive on <u>Apr 8</u> , 1958, and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Apr 14 '58							
ACTUAL SIGNATURE <i>J. J. Frampton and Son</i>		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 13, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Rhodesdale Cemetery		22d. LOCATION (City, town, or county) (State) Near Rhodesdale, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE Apr 17 '58	
						24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

MANHATTAN STATE DEPARTMENT OF HEALTH-BALTIMORE, 19

CERTIFICATE OF DEATH

BURZAU V. A.

APR 17 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4558

CERTIFICATE OF DEATH

Reg. Dist. No.

04538

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 2 years Mo					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast					
3. NAME OF DECEASED (Type or print) Keino		First Finnberg	Middle Last Month Day Year April 18 1958				
4. DATE OF DEATH	Month Month	Day Days	Year Hours Min.				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29 1887				
9. AGE (In years lost birthday) 71 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	11. KIND OF BUSINESS OR INDUSTRY BUILDING	12. BIRTHPLACE (State or foreign country) SWEDEN				
13. FATHER'S NAME No INFORMATION	14. MOTHER'S MAIDEN NAME No INFORMATION	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					
16. SOCIAL SECURITY NO. 092-09-1372	17. INFORMANT Eastern Shore State Hospital records	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH LINK							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) North East	(County) Cecil	(State) Md.
21. I certify that I attended the deceased from Feb 11, 1958, to April 18, 1958, that I last saw the deceased alive on April 18, 1958, and that death occurred at 4:45 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md.				ADDRESS (Street, city or town, state)		DATE SIGNED April 18 '58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-58	22c. NAME OF CEMETERY OR CREMATORIAL Methodist	22d. LOCATION (City, town or county) North East Cecil			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Crane		ADDRESS Northeast	24a. REC'D BY REGISTRAR APR 22 '58	24b. REGISTRAR'S SIGNATURE W. H. Keenan			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4559

CERTIFICATE OF DEATH

04539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 42 yrs. 11 mo. 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		29x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edward	Middle -	Last Gray	4. DATE OF DEATH April	Month 22	Day 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Gray		14. MOTHER'S MAIDEN NAME Unknown		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT RECORDS: Eastern Shore State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 <i>Chronic myocarditis & Acute dilatation</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) <i>Arterio-sclerosis generalized</i>		INTERVAL BETWEEN ONSET AND DEATH			
		DUE TO (c) <i>Chronic Brain syndrome & psychosis -</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I attended the deceased from <u>11-11</u> , 19 <u>56</u> , to <u>April 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>58</u> , and that death occurred at <u>7 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edwin Ward, M.D., Cambridge, Maryland							
DATE SIGNED 4-23-58							
ACTUAL SIGNATURE <i>Edwin Ward</i>							
PHYSICIAN'S NAME (Type) Edwin Ward Eastern Shore State Hospital, Cambridge, Maryland							
22a. BURIAL/CREMATION REMOVAL (Specify) Anatomy Bd.		22b. DATE THEREOF 4-25-1958		22c. NAME OF CEMETERY OR CREMATORIUM Md. Med. School		22d. LOCATION (City, town, or county) Baltimore	
(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas Cambridge Md.		ADDRESS		24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE W. L. Schuck	
VS A15 (4) 15M 9/55							

6359 CERTIFICATE OF DEATH

APR 29 1959

RECEIVED
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4560

Item 8, Film G228, 4/28/58 Icy

CERTIFICATE OF DEATH

Reg. Dist. No.

04540

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Dorchester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Surfside</i>		c. LENGTH OF STAY IN MD <i>18 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Surfside</i>		d. STREET ADDRESS <i>Taylor Ave</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Samuel Francis Harrison</i>		First <i>Samuel</i>	Middle <i>Francis</i>	Last <i>Harrison</i>	4. DATE OF DEATH <i>4/19/1958</i>	Month <i>4</i>	Day <i>19</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/29/1884</i>		9. AGE (In years (not birthday) yrs. <i>74</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sixty years</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Samuel R. Harrison</i>		14. MOTHER'S MAIDEN NAME <i>Lester Anne Tarbutton</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Mary Alice Harrison</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		a. <i>Acute Coronary Occlusion</i> 10 min						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Arteriosclerosis</i>		b. <i>Arteriosclerosis</i> 10 yrs						
(c) DUE TO <i>Generalized Arteriosclerosis</i>		c. <i>Generalized Arteriosclerosis</i> 12-15 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>April 19 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Preston, Md</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>4-23</i> , 19 <i>51</i> , to <i>4-19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4-26</i> , 19 <i>58</i> , and that death occurred at <i>7:30</i> AM, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Sandy B. Plummer</i>		ADDRESS (Street, city or town, state) <i>Preston, Md</i>						
PHYSICIAN'S NAME (Type) <i>DR. H. B. PLUMMER</i>		DATE SIGNED						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/22/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington</i>		22d. LOCATION (City, town, or county) <i>Surfside</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hilloughby, East New Market</i>		ADDRESS <i>John J. Hilloughby, East New Market</i>		24. REC'D BY REGISTRAR DATE <i>APR 24 '58</i>		25. REGISTRAR'S SIGNATURE <i>John J. Hilloughby, East New Market</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGEIAE
APR 2 1962
SURREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4561

CERTIFICATE OF DEATH

Reg. Dist. No. 04541

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>Apr. 14, 1958</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trappe Md - 20222</i>	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Della</i>	Middle <i>Heath</i>	4. DATE OF DEATH <i>4 29 1958</i>
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG 12, 1875</i>
9. AGE (In years last birthday) <i>79 yrs.</i>		10. IF UNDER 1 YEAR Months <i>1</i>	11. IF UNDER 24 HRS. Days <i>29</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>St. Marys Co. Maryland</i>
13. FATHER'S NAME <i>John Haunkeff</i>		14. MOTHER'S MAIDEN NAME <i>Jessie ? Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Carroll L. Heath Trappe Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Chronic myocarditis</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>—</i>		DUE TO <i>Atherosclerosis. General</i>	
		DUE TO <i>Cir. Brain syndrome with psychosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Undernourished. Underweight</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>—</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4-14 — 1958</i> to <i>4-29 — 1958</i> that I last saw the deceased alive on <i>— 19 —</i> , and that death occurred at <i>— M. from the causes and on the date stated above.</i> ADDRESS (Street, city or town, state) <i>—</i>		DATE SIGNED <i>—</i>	
ACTUAL SIGNATURE <i>Edwin J. Ward</i>	M.D.		
PHYSICIAN'S NAME (Type) <i>Edwin J. Ward M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 23 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>LORRAINE CEM.</i>	22d. LOCATION (City, town, or county) (State) <i>BALTIMORE MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Newmyer</i>	ADDRESS <i>Eastern Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 5 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Edwin J. Ward</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04542

Reg. Dist. No.

1		4543							
1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Col.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS Cambridge Md. RFD # 3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital DOA						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James		First	Middle	Last	4. DATE OF DEATH April 16, 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/17	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pumping Sta. Operator		10b. KIND OF BUSINESS OR INDUSTRY Dor. Water Co.		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Herbert Higgins		14. MOTHER'S MAIDEN NAME Mattie Creamer							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 217-09-9050		17. INFORMANT Mrs James Higgins Cambridge Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/18/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/58	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Funeral		ADDRESS LeCompte Funeral Service Cambridge Md.		24a. REC'D BY REGISTRAR APR 21 1958		24b. REGISTRAR'S SIGNATURE John LeCompte			
VS. A15ME(5) 5M 9/55									

BUREAU Y. S.

APR 21 1968

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04543

4544

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 20 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 Douglas Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Levin	Middle .	Last Hollis
4. DATE OF DEATH	Month April	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1910
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barbering	11. BIRTHPLACE (State or foreign country) Dorchester County, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Hollis	
14. MOTHER'S MAIDEN NAME Stella Baltimore		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-16-4542		17. INFORMANT Address Mrs Lillian Hollis, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas			
INTERVAL BETWEEN ONSET AND DEATH 157X			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1954 , to April 7, 1958 , that I last saw the deceased alive on April 7, 1958 , and that death occurred at 1 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 4-9-58			
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		M.D.	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 4/10/1958		22c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	
22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Clark Jr.</i>		24a. REC'D BY REGISTRAR DATE APR 18 '58	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE <i>Quinton</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU U. S.

APR 18 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4545 Items 8, 9 Film G229 5-19-58 et

Reg. Dist. No. 04544

1. PLACE OF DEATH a. COUNTY Dorchester Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	c. LENGTH OF STAY IN 1b 30 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 309 Oakley St.		d. STREET ADDRESS 309 Oakley St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William	First C.	Middle Johnston	Last
4. DATE OF DEATH April 20, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1900 / 1901
9. AGE (in years last birthday) 67 56 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Hardware	
11. BIRTHPLACE (State or foreign country) Kennedyville Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Johnston		14. MOTHER'S MAIDEN NAME Emma Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 161-01-6896 17. INFORMANT Mrs William C. Johnston 309 Oakley St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1		Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 4/22/58	
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/58	
22c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cemetery		22d. LOCATION (City, town, or county) Cambridge	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.		24a. REC'D BY REGISTRAR APR 24 1958	
		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

BUREAU V. S.

APR 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4546

CERTIFICATE OF DEATH

04545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN THE <i>5 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>	
d. STREET ADDRESS <i>1412 Henry St</i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sophie</i>		First	Middle
4. SEX <i>Female</i>		Last	5. DATE OF DEATH <i>4/17/58</i>
6. COLOR OF FACE <i>White</i>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH <i>3/11/1881</i>
8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dorchester</i>		9. 10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
10c. BIRTHPLACE (State or foreign country) <i>Germany</i>		11. 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Don't know</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Carl Koch, Cambridge MD</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>INSTANT</i>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/20</i> , 19 <i>55</i> to <i>17 APRIL</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>13 APRIL</i> , 19 <i>58</i> , and that death occurred at <i>?</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Walter E. Gunby Jr</i>		ADDRESS (Street, city or town, state) <i>105 CHURCH ST. CAMBRIDGE MD.</i>	
22a. DATE, TIME, & PLACE OF BURIAL, CREMATION, REMOVAL (Specify) <i>4/17/58</i>		22b. DATE, TIME, & PLACE OF CEMETERY OR CEMETORY <i>East New Market</i>	
22c. LOCATION (City, town, or county) <i>East New Market, MD</i>		22d. REGISTRAR'S SIGNATURE <i>Walter E. Gunby</i>	
23. FUNERAL-DIRECTOR'S SIGNATURE <i>Walter E. Gunby</i>		24. ADDRESS <i>East New Market</i>	
25. REC'D. BY REGISTRAR <i>APR 23 '58</i>		26. REGISTRAR'S SIGNATURE <i>Walter E. Gunby</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGISTRATION

REGISTRATION

REGISTRATION

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REGISTRATION

BUREAU N.Y.

APR 23 1923

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4562

CERTIFICATE OF DEATH

14546

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aireys Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aireys Ms.		d. STREET ADDRESS Aireys RFD # 2 Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aireys Md.				d. STREET ADDRESS Aireys RFD # 2 Cambridge Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lynn		First B.	Middle Marshall	4. DATE OF DEATH April	Month 3	Day 19	Year 58
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/1888		9. AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Aireys Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Marshall				14. MOTHER'S MAIDEN NAME Mary Ester Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 1		17. INFORMANT None		Address Mrs Lynn Marshall Aireys Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>		442X DUE TO		renal disease		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Arteriosclerotic hypertensive cardio vascular</u>		DUE TO				10 years	
		(c) <u>Arteriosclerosis, generalized</u>				10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hemiplegia, right					
20c. TIME OF INJURY Hour o. m. --- 19 p. m. ---		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from <u>December 1, 1945</u> , to <u>April 3, 1958</u> , that I last saw the deceased alive on <u>March 31, 1958</u> , and that death occurred at <u>8:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D. <u>15 Locust Street, Cambridge, Md. 4-4-58.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/58		22c. NAME OF CEMETERY OR CREMATORIAL East New Market Cemetery		22d. LOCATION (City, town, or county) East New Market, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE <u>W. B. LeCompte</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH



BUREAU Y. S.

APR 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04547

Item 9, Film G227, 4/16/58

4563

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN lb
RURAL and give nearest town)

1 mo. 4 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Eastern Shore State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Talbot

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Trappe

20 x -2

d. STREET ADDRESS

-

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
JosephMiddle
RobertLast
McQuay4. DATE
OF
DEATH
AprilMonth
Day
Year
8 19 58

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

December 24, 1871

9. AGE (In years
last birthday)

85 87 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Unemployed

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert McQuay

14. MOTHER'S MAIDEN NAME

Venia James

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

--

17. INFORMANT

RECORDS: Eastern Shore State Hospital

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o)

443X

Hypertensive arteriosclerotic heart disease

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

Conditions, if any, which
gave rise to immediate
cause (o), stating the under-
lying cause last.

DUE TO

(b)

Generalized arteriosclerosis

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
White Not white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Mar. 4, 1958 to April 8, 1958, that I last saw the deceased
alive on April 7, 1958, and that death occurred at 6:40 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Ettore DeFilippis

M.D. Cambridge, Maryland

4-8-58

PHYSICIAN'S
NAME (Type)

Ettore DeFilippis

Eastern Shore State Hospital, Cambridge, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 4/11/58

DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Bogman Cemetery

22d. LOCATION (City, town, or county)

Bogman, Md

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Hamilton Harrison, Jr. Michaels

ADDRESS

24a. REC'D BY REGISTRAR
APR 14 1958

DATE

24b. REGISTRAR'S SIGNATURE
John E. Deacon

87-3108672A0-072434 80 740472A00 3A72 011572A0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4564

CERTIFICATE OF DEATH

04548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market Md.		c. LENGTH OF STAY IN 1b 6 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East New Market Md.			d. STREET ADDRESS East New Market Md.		
3. NAME OF DECEASED (Type or print) Nicye			First Spear	Middle Merrick	4. DATE OF DEATH April 5, 1958
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/13/63	9. AGE (In years from birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Dorchester Co.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert W. Spear			14. MOTHER'S MAIDEN NAME Roseann Paul		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mattie Merrick	Address East New Market Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral haemorrhage</u> INTERVAL BETWEEN 422.1 ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Arterio-sclerotic CVD.</u> (c) <u>Arterio-sclerotic generalized</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED White	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 3, 1958</u> , to <u>April 5, 1958</u> , that I last saw the deceased alive on <u>April 3, 1958</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John Thompson</u> M.D. <u>Cambridge, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58	22c. NAME OF CEMETERY OR CREMATORIAL Eats New Market Cemetery	22d. LOCATION (City, town, or county) East New Market	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service			ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR APR 9 '58	24b. REGISTRAR'S SIGNATURE W. LeCompte

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 9 1968

RECEIVE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
: MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04549

Reg. Dist. No.

4547

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester Co. MARYLAND		a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Dorchester Co.	
Cambridge Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b		c. STREET ADDRESS Talbot Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Talbot Ave.			
3. NAME OF DECEASED (Type or print)		First	Middle
Robert		R.	Mills
4. DATE OF DEATH		Month	Day
April		21,	19 58
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
6/23/82		75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Merchant		Store	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Dorchester Co.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Robert Mills		Lucretia Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
Howeth Mills		Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED
Hour a. m. p. m.		19	While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE		DATE SIGNED	
Dr. John Mace Jr.		4/22/58	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		22c. NAME OF CEMETERY OR CREMATORIAL	
		22d. LOCATION (City, town, or county) (State)	
		Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
LeCompte Funeral Service		24b. REGISTRAR'S SIGNATURE	
		APR 24 '58	
		D. L. LeCompte	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE PENITENTIARY
WISCONSIN STATE PENITENTIARY
DEPARTMENT OF CORRECTION

FEDERAL BUREAU OF INVESTIGATION

APR 24 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04550

4565

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Wicomico	
c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 2212-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 223 High Street St.	
3. NAME OF DECEASED (Type or print) First James Middle Waples Last Mitchell		4. DATE OF DEATH April 10 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 4, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Burkett Mitchell		14. MOTHER'S MAIDEN NAME Mary Hastings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT RECORDS: Mrs. Carrie Boyce, Mitchell (Wife) Eastern Shore State Hospital 223 High St. Salisbury, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-2 DUE TO Bronchial pneumonia INTERVAL BETWEEN ONSET AND DEATH — Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Myocarditis — DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491 Chronic Brain Syndrome assoc. with Senile Brain Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1958, to April 10, 1958, that I last saw the deceased alive on April 10, 1958, and that death occurred at 11:58 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edwin J. Ward</i> ADDRESS (Street, city or town, state) M.D. Cambridge, Maryland DATE SIGNED 4-10-58			
22a. PHYSICIAN'S NAME (Type) Edwin J. Ward		22b. EASTERN SHORE STATE HOSPITAL, CAMBRIDGE, MARYLAND	
22c. BURIAL, CREMATION, REMOVAL Burial Apr. 13, 1958		22d. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery	
22e. LOCATION (City, town, or county) Salisbury, Maryland		22f. DATE APR 14 1958	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. ADDRESS SALISBURY MARYLAND	
24b. REC'D BY REGISTRAR DATE		24c. REGISTRAR'S SIGNATURE O. C. S.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU
MAY 14 1929

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG227 4-14-58 et

04551

4548

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Vienna Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Angenora	First Layton	Middle Murphy	Last April 3, 1958
4. DATE OF DEATH Month April	Day 3	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1870 1878
9. AGE (In years lost birthday) 79	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Vienna	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William J. Layton	14. MOTHER'S MAIDEN NAME Laura McNamara		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs Horold Richardson	Address Vienna Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		INTERVAL BETWEEN ONSET AND DEATH 19 days Central Hemorrhage Cerebral Arterio sclerosis (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/15/58</u> , 19 <u>58</u> , to <u>4/3/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/3/58</u> , 19 <u>58</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type) Lawrence Maryanor	ADDRESS (Street, city or town, state) 136 Race St. Cambridge, Md DATE SIGNED 4/7/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/16/58	22c. NAME OF CEMETERY OR CREMATORIAL Vienna Cemetery	22d. LOCATION (City, town, or county) (State) Vienna Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE APR 9 '58	24b. REGISTRAR'S SIGNATURE Ole Stouch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87 ROMITAG-HEATH 20 PRACTICAL STATEMENTS

BUREAU Y.

APR 9 1958

REGELEY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4566

CERTIFICATE OF DEATH

Reg. Dist. No.

04552

1. PLACE OF DEATH a. COUNTY DORCHESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 4 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELMER	Middle THEODORE	Last ORME
4. DATE OF DEATH APRIL	Month 4	Day 1958	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-76
9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 81	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY Antique	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Elmer L. Orme	14. MOTHER'S MAIDEN NAME Mary Bess Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 215-61-2633	17. INFORMANT EASTERN SHORE STATE HOSPITAL RECORDS	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0			
DUE TO ARTERIOSCLEROTIC HEART DISEASE			
INTERVAL BETWEEN ONSET AND DEATH SEVERAL YRS			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO GENERALIZED ARTERIOSCLEROSIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from 11-14, 1957 to 4-4, 1958 that I last saw the deceased alive on 4-4, 1958 , and that death occurred at 2:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George E. Currier		ADDRESS (Street, city or town, state) Eastern Shore State Hospital	
PHYSICIAN'S NAME (Type) GEORGE E. CURRIER		DATE SIGNED Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) April 7, 1958		22b. DATE THEREOF April 7, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Denton		22d. LOCATION (City, town, or county) Denton	
23. FUNERAL DIRECTOR'S SIGNATURE John Clark		24a. REC'D. BY REGISTRAR APR 7 1958 DATE	
ADDRESS Denton Md		24b. REGISTRAR'S SIGNATURE John Clark	

81. ДРОМІДАВ-НІДАВ! ЩО ТІЧЕМУСЯ СЕЗАМІДАСТРАВА!

BUREAU V. S.

APR 7 1958

РЕГЕИВ ЕД

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tombstone permit. File pages 1 and 2 with the registrar prior to burial, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge—Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Donald		d. STREET ADDRESS 10 Bunker Street	
First Middle Last		4. DATE OF DEATH April 26, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1953
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Russell Payne		14. MOTHER'S MAIDEN NAME Dorothy Courtney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dorothy C. Payne, Academy St., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial injury</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple fractures skull</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 15 Min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was hit by auto on street.	
20c. TIME OF INJURY Hour 1 PM p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Cambridge	
(County) Dor.		(State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Nutrol causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 4/27/58	
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 29, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM St. James Cemetery		22d. LOCATION (City, town, or county) Johnson City, New York (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Thomas</i>		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE APR 29 '58		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

RECEIVED - EXHIBIT - BUREAU OF INVESTIGATION - BALTIMORE, MD

BUREAU V. A.

APR 29 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4567

CERTIFICATE OF DEATH

04554

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE				
Dorchester MARYLAND		Maryland Nicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb				
Cambridge		10 mo.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Eastern Shore State Hosp.		Willards 22x-2				
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle			
MARY ELLEN PENNEWELL		Last	4. DATE OF DEATH			
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH			
Female	white	Mar. 24, 1865	9. AGE (In years lost birthday) yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
None		Maryland	M. S. A.			
13. FATHER'S NAME	14. MOTHER'S M AIDEN NAME					
Isaac Haddock	Emma Snack					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT	Address			
	none	Hospital Records	Eastern Shore State Hosp.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease						
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.						
(b) General Arteriosclerosis						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>57</u> , to <u>April 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>58</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE	ETTORE DE FILIPPIS M.D.			DATE SIGNED		
PHYSICIAN'S NAME (Type)	ETTORE DE FILIPPIS			Cambridge, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL Freedoms		22d. LOCATION (City, town, or county) Kittsville, Md.		
Burial	4/15/58	Freedoms		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
Peter Whaley, Salliville, Del.			DATE APR 16 '58	Quinton		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED

1969

MAY 1969

BUREAU V. S.

APR 16 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4550 CERTIFICATE OF DEATH

04555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.		d. STREET ADDRESS 1 Cambridge Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Earl T.		First	Middle	Last	4. DATE OF DEATH April	Month	Day	Year		
S. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1873	9. AGE (in years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Columbus Richardson				14. MOTHER'S MAIDEN NAME Sarah Christopher						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr James Richardson		Address Lloyds Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x		INTERVAL BETWEEN ONSET AND DEATH CARDIOVASCULAR RENAL DISEASE 6 WEEKS								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC ASTHMA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) 105 CHURCH ST		(County) MD	(State) 58	
21. I certify that I attended the deceased from 7 DEC , 1949, to 13 APRIL , 1958, that I last saw the deceased alive on 13 APRIL , 1958, and that death occurred at 11:40 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) WALTER E. GUNBY JR							DATE SIGNED 14 APRIL 58	
ACTUAL SIGNATURE										
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/58		22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE W. LeCompte				

CERTIFICATE OF DEATH

1958

BUREAU Y.

APR 21 1958

RECEIVED

1
FOR STATE
HEALTH DEPT.

Health
Board of Health

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If any delay is necessary, please
execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4568

04556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hurlock, Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harrison Ferry Bridge		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Newell Middle Jester Last Robinson		4. DATE OF DEATH Month April Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Heating	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William L. Robinson		14. MOTHER'S MAIDEN NAME Laura Insley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] NO		16. SOCIAL SECURITY NO. 214-03-4935 17. INFORMANT Mrs. Newell Robinson Hurlock, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 975x Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned self in creek.	
20c. TIME OF INJURY Hour 4 a. m. 4 p. m. 1/24/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Creek	20f. (City or town) (County) (State) Near Hurlock, Dor. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr. John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/28/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/58	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dorchester Mem. Park	22d. LOCATION (City, town, or county) (State) Cambridge, Dor. Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	24a. REC'D BY REGISTRAR APR 30 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred LeCompte</i>

RECEIVED

APR 30 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and only event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 4569 CERTIFICATE OF DEATH

04557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b About 15 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edward	Middle Sampson	4. DATE OF DEATH April 26 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH About 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland
13. FATHER'S NAME Andrew Sampson		14. MOTHER'S MAIDEN NAME Lina Whittington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Algie Sampson, East New Market, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day Cerebral Hemorrhage	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/25, 1958, to 4/26/1958, that I last saw the deceased alive on 4/25/1958, and that death occurred at 10 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence Maryanov	ADDRESS (Street, city or town, state) 136 Race St. Cambridge, Md.		
PHYSICIAN'S NAME (Type) Lawrence Maryanov, M.D.	DATE SIGNED 4/28/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 28, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Thompsonstown Cemetery	22d. LOCATION (City, town, or county) Near East New Market, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland	ADDRESS J. J. Frampton and Son, Federalsburg, Maryland	24a. REC'D BY REGISTRAR DATE MAY 1 '58	24b. REGISTRAR'S SIGNATURE Albert Leach

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4570 Item 11 Film G227 1-74-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 04558

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Caroline		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		d. STREET ADDRESS Denton 05 x-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EMMA Jane		First	Middle	Last	4. DATE OF DEATH April 4	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6 1872		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Hill		14. MOTHER'S MOTHER'S NAME Mary Walker						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Eastern Shore State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>unk</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from <i>Mar 27, 1958</i> , to <i>April 4, 1958</i> , that I last saw the deceased alive on <i>April 4, 1958</i> , and that death occurred at <i>10³⁰ AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Thomas J. Dredge</i> M.D. <i>E.S.S. Hospital, Cambridge, Md.</i> <i>April 4 58</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Apr. 8, 1958</i>		22b. DATE THEREOF <i>Apr. 8, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>		22d. LOCATION (City, town, or county) <i>Denton, Md.</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John V. Moore Son Denton</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>Apr. 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Asst. Secy.</i>		

CERTIFICATE OF DEATH

NAME

ADDRESS

NAME

NAME OF PERSON IN CHARGE OF DEATH

DEATH

DEATH

BUREAU N. 2

APR 9 1969

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04559

Reg. Dist. No.

4551

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 2 Locust Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ernestine		First	Middle	Lost	4. DATE OF DEATH April 13, 1958	Month	Day	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Dec. 3, 1886	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William Taylor		14. MOTHER'S MAIDEN NAME Gertrude Eaton Hart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No 214-07-7300		17. INFORMANT Ernestine M. Merrick, Glenburn Ave., Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8		DUE TO Carcinoma Bowel				INTERVAL BETWEEN ONSET AND DEATH 1 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cambridge	(County)	(State)	
21. I certify that I attended the deceased from 12-28, 1957, to 4-13, 1958, that I last saw the deceased alive on 4-13, 1958, and that death occurred at 2:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-14-58								
ACTUAL SIGNATURE S. B. Bannerman		M.D.						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 15, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Horner		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DAPR 21 '58		24b. REGISTRAR'S SIGNATURE J. W. French		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 4552 CERTIFICATE OF DEATH

Reg. Dist. No. 04560

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 Pine Street		d. STREET ADDRESS 121 Pine Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Minnie	First	Middle	Last
4. DATE OF DEATH Apr. 17, 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1898
9. AGE (In years lost birthday) 59 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	14. KIND OF BUSINESS OR INDUSTRY Housewife	15. BIRTHPLACE (State or foreign country) Dorchester Co., Md	16. CITIZEN OF WHAT COUNTRY? USA
17. FATHER'S NAME John Kiah		18. MOTHER'S MAIDEN NAME Henrietta Clash	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		20. SOCIAL SECURITY NO. 220-32-9527	
21. INFORMANT Mrs. Iona K. Coleman, Cambridge, Md.		22. ADDRESS	
23. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 156.1		24. INTERVAL BETWEEN ONSET AND DEATH ?	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost. (b)			
DUE TO (c)			
25. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Malnutrition, hypotension, essential			
26. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. ADDRESS (Street, city or town, state) Cambridge, Md.	
28. DATE SIGNED Apr. 17, 1958			
29. MEDICAL CERTIFICATION		30. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
31. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		32. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) Cambridge, Md.	
33. (County) Cambridge, Md.		(State) Md.	
34. I certify that I attended the deceased from Nov. 17, 1957 , to Apr. 17, 1958 , that I last saw the deceased alive on Apr. 15, 1958 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md.			
35. ACTUAL SIGNATURE James U. Thompson		36. DATE SIGNED Apr. 17, 1958	
37. PHYSICIAN'S NAME (Type) James U. Thompson			
38. BURIAL, CREMATION, REMOVAL (Specify) Burial		39. DATE THEREOF 4/20/1958	
40. NAME OF CEMETERY OR CREMATORIAL Waugh Cemetery		41. LOCATION (City, town, or county) Cambridge, Maryland	
42. ADDRESS Cambridge, Md.		(State) Md.	
43. FUNERAL DIRECTOR'S SIGNATURE Herb M. Galt Jr.		44. REC'D BY REGISTRAR Apr. 21 '58	
45. ADDRESS Cambridge, Md.		46. REGISTRAR'S SIGNATURE John E. Queen	

CERTIFICATE OF DEATH

BUREAU Y. 5
REGISTRY

APR 21 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04561

4553 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lloyds Md.		d. STREET ADDRESS Lloyds Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First W.	Middle Wheatley	Last	4. DATE OF DEATH April 9, 1958	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/86	9. AGE (In years last birthday) 71	10. IF UNDER 1 YEAR yrs.	11. IF UNDER 24 HRS. Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Neck Dist. Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Wheatley		14. MOTHER'S MAIDEN NAME Amanda Marshall							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-12-1601		17. INFORMANT Mrs. William Wheatley		Address Lloyds Md.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.0		Acute Pancreatitis				INTERVAL BETWEEN ONSET AND DEATH 10 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260x Chronic Purulent otitis media and Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 3-28-58, 19, to 4-9-58, 19, that I last saw the deceased alive on 4-9-58, 19, and that death occurred at 5 A M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Albert E. Bunker</i>									
PHYSICIAN'S NAME (Type)		Albert E. Bunker, M. D.		Cambridge, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/58		22c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE APR 15 '58		24b. REGISTRAR'S SIGNATURE <i>Albert LeCompte</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 389M1400-RT1A81597191784930 31A2 391A1784930

BUREAU V. 2

APR 15 1969

REGIYED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04562

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 11 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nathan		First Willis	Middle Willis
4. DATE OF DEATH April 13 1958		Month Day Year	Lost
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1897	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman	
10b. KIND OF BUSINESS OR INDUSTRY Any		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles H. Willis	
14. MOTHER'S MAIDEN NAME Flora M. Nichols		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown	
16. SOCIAL SECURITY NO. —		17. INFORMANT Records E.S.S. Hospital Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Instant	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary occlusion	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED 4/13/58	
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 4-16-1958		22c. NAME OF CEMETERY OR CREMATORIUM Friends Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph W. Grant</i>		22d. LOCATION (City, town, or county) Calvert North East & Prince George	
VS. AT 5ME 5M 2/57		ADDRESS North East Maryland	
24e. REGISTRY REGISTRAR APR 16 '58		24f. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
1958

BUREAU V. 2

APR 16 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4554 CERTIFICATE OF DEATH

Reg. Dist. No.

04563

1. PLACE OF DEATH o. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md.		b. COUNTY Dorchester Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Toddville Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Toddville Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Olive	Middle Mills	Last Windsor	4. DATE OF DEATH April	Month 19,	Day 19	Year 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/84		9. AGE (In years lost birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bishops Head Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Caleb Mills		14. MOTHER'S MAIDEN NAME Dulcenia Moore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Anita Windsor		Address Toddville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost. DUE TO (b) with metastasis						INTERVAL BETWEEN ONSET AND DEATH 2 years(!)	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Toddville	(County) Md.
20f. (City or town) Toddville						(State) Md.	
21. I certify that I attended the deceased from Sept 11, 1957 to Apr. 19, 1958 that I last saw the deceased olive on Apr. 19, 1958, and that death occurred at 11:54 A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1 Locust St.		DATE SIGNED	
ACTUAL SIGNATURE Lewis M. Burdette, M.D.							
PHYSICIAN'S NAME (Type) Lewis M. Burdette							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/58		22c. NAME OF CEMETERY OR CREMATORIAL Zion Church Cemetery		22d. LOCATION (City, town, or county) Toddville	
22d. LOCATION (City, town, or county) Toddville						(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR APR 20 '58		24b. REGISTRAR'S SIGNATURE W. L. Lewis	
				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 3000118-97103-00 TRENTESSA STATE GRAYHAWK

BUREAU K-5
APR 23 1958
RECEIVED